IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF VIRGINIA
BIG STONE GAP DIVISION

PEGGY A. ADAMS,	)	
Plaintiff	)	
	)	
v.	)	Civil Action No. 2:03cv00140
	)	**REPORT AND**
	)	**RECOMMENDATION**
JO ANNE B. BARNHART,	)	
Commissioner of Social Security,	)	By: PAMELA MEADE SARGENT
Defendant	)	United States Magistrate Judge

I. Background and Standard of Review

Plaintiff, Peggy A. Adams, filed this action challenging the final decision of the Commissioner of Social Security, ("Commissioner"), denying plaintiff's claims for disability insurance benefits, ("DIB"), and supplemental security income, ("SSI"), under the Social Security Act, as amended, ("Act"), 42 U.S.C.A. §§ 423 and 1381 *et seq*. (West 2003). Jurisdiction of this court is pursuant to 42 U.S.C. §§ 405(g) and 1383(c)(3). This case is before the undersigned magistrate judge by referral pursuant to 28 U.S.C.A. § 636(b)(1)(B) (West 1993 & Supp. 2004). As directed by the order of referral, the undersigned now submits the following report and recommended disposition.

The court's review in this case is limited to determining if the factual findings of the Commissioner are supported by substantial evidence and were reached through application of the correct legal standards. *See Coffman v. Bowen*, 829 F.2d 514, 517

(4th Cir. 1987). Substantial evidence has been defined as "evidence which a reasoning mind would accept as sufficient to support a particular conclusion. It consists of more than a mere scintilla of evidence but may be somewhat less than a preponderance." *Laws v. Celebrezze*, 368 F.2d 640, 642 (4th Cir. 1966). "'If there is evidence to justify a refusal to direct a verdict were the case before a jury, then there is "substantial evidence."'" *Hays v. Sullivan*, 907 F.2d 1453, 1456 (4th Cir. 1990) (quoting *Laws*, 368 F.2d at 642).

The record shows that Adams protectively filed her current applications for DIB and SSI on or about December 14, 1999, alleging disability as of March 22, 1996, based on a ruptured disc, low back pain, shoulder pain, neck pain and numbness in the legs and hands. (Record, ("R."), at 320-22, 335, 509-12.)[1] Her claims were denied initially and on reconsideration. (R. at 303-05, 306, 308-09.) Adams then requested a hearing before an administrative law judge, ("ALJ"). (R. at 310.) These claims and Adams's prior claims were consolidated for hearing, which was held on October 31, 2000, and at which Adams was represented by counsel. (R. at 560-606.)

By decision dated November 16, 2000, the ALJ again denied Adams's claims. (R. at 274-83.) The ALJ found that Adams met the disability insured status

[1]The record indicates that Adams protectively filed prior applications for DIB and SSI on April 12, 1996, which were denied initially and on reconsideration. (R. at 49-51, 52, 54-55, 67.) After a hearing, the ALJ issued a decision on October 15, 1997, denying Adams's claims. (R. at 12-19.) Adams requested review of the ALJ's decision, but the Appeals Council denied her request for review. (R. at 5-6, 8.) Adams then filed a civil action in the United States District Court for the Western District of Virginia. On May 9, 2000, the Commissioner moved to remand Adams's claims. (R. at 520-21.) By order dated May 22, 2000, the Commissioner's motion was granted and Adams's claims were remanded for further administrative proceedings. (R. at 519.)

requirements of the Act on March 20, 1996, and continued to meet them through the date of the decision. (R. at 281.) The ALJ also found that Adams had not engaged in substantial gainful activity since March 20, 1996. (R. at 281.) The ALJ found that Adams had severe impairments, namely degenerative arthritis of the lumbar spine, degenerative disc disease of the cervical spine and hypertension, but he found that Adams did not have an impairment or combination of impairments listed at or medically equal to one listed at 20 C.F.R. Part 404, Subpart P, Appendix 1. (R. at 281.) The ALJ found that Adams's allegations were not credible to the extent alleged. (R. at 281.) The ALJ concluded that Adams had the residual functional capacity to perform light work,[2] diminished by an inability to stand, walk or sit for more than one hour each without interruption, an ability to only occasionally stoop, kneel, crouch and crawl, an inability to climb or kneel, a restriction in the pushing and pulling of foot controls and a restriction from exposure to heights, moving machinery, temperature extremes, humidity and vibration. (R. at 282.) Thus, the ALJ found that Adams was unable to perform her past relevant work as a sewing machine operator. (R. at 282.) Based on Adams's age, education and residual functional capacity and the testimony of a vocational expert, the ALJ found that a significant number of jobs existed in the national economy that Adams could perform, including those of a cashier, an information clerk, an order clerk, a hand packager, a sorter, an assembler, an inspector, a ticket seller and a cafeteria attendant. (R. at 283.) Thus, the ALJ found that Adams was not under a disability as defined in the Act at any time through the date of the decision and was not eligible for benefits. (R. at 283.) *See* 20 C.F.R. §§ 404.1520(g), 416.920(g) (2004).

[2]Light work involves lifting items weighing up to 20 pounds at a time with frequent lifting or carrying of items weighing up to 10 pounds. If someone can perform light work, she also can perform sedentary work. *See* 20 C.F.R. §§ 404.1567(b), 416.967(b) (2004).

After the ALJ issued his opinion, Adams again pursued her administrative appeals, (R. at 257-68), but the Appeals Council denied her request for review. (R. at 254-56.) Adams then filed this action seeking review of the ALJ's unfavorable decision, which now stands as the Commissioner's final decision. *See* 20 C.F.R. §§ 404.981, 416.1481 (2004). The case is before this court on Adams's motion for summary judgment filed April 8, 2004.

II. Facts

Adams was born in 1955, (R. at 24, 59, 564), which classifies her as a "younger person" under 20 C.F.R. §§ 404.1563(c), 416.963(c) (2004). She obtained her general equivalency development, ("GED"), diploma and has past relevant work experience as a sewing machine operator and a deli cook. (R. at 25-26, 71, 565, 570.)

Adams testified at her hearings that she suffered low back pain resulting from two herniated discs. (R. at 28.) She stated that she injured her back in 1991 or 1992 while caring for her sick aunt, and she stated that her condition had worsened since that time. (R. at 29.) Adams testified that she stopped working on March 20, 1996. (R. at 29, 565, 567-68, 574.) She stated that the pain was constant and radiated into her right leg, causing it to give way. (R. at 29, 576.) Adams testified that she took Lortab as needed, but took only Tylenol or Tylenol PM on a regular basis. (R. at 40.) She further testified that she received Toradol injections every three weeks. (R. at 577.) Adams stated that she could not touch her toes or squat. (R. at 40.)

Adams testified that she also suffered from pain and numbness in her right arm,

fingers, elbow, wrist and shoulder, which caused difficulty writing and gripping objects. (R. at 30-31, 580.) Adams further testified that she experienced daily incontinence related to her back problems. (R. at 31, 576-77.) Adams stated that she suffered from arthritis in her back resulting in an aching, throbbing pain. (R. at 31-32.) At her second hearing, Adams testified that she experienced left-sided neck and shoulder pain, for which she had received steroid injections. (R. at 577.) She stated that she had difficulty lifting her left arm over her shoulder. (R. at 578.) She stated that she was then currently being treated for severe, malignant hypertension that was worsened by her back pain, but which was coming under control with medication. (R. at 32-33, 580-81.) Adams stated that she experienced headaches as a result of hypertension, but that they had lessened in frequency since her hypertension had begun to come under control. (R. at 581.) Adams also stated that Tylenol helped ease her headaches. (R. at 582.)

Adams testified that she suffered from acute bronchitis and asthma. (R. at 34-35.) She stated that hot temperatures made her smother, and she noted that she was instructed by her doctor to keep her house as dust-free as possible. (R. at 38.) Adams further noted that she had suffered from bilateral carpal tunnel syndrome for the previous three or four years, for which Dr. Kiser had mentioned surgery, but which she could not afford because she lacked insurance. (R. at 579.) Adams testified that she had suffered breast cancer since the initial hearing and had undergone four breast biopsies, none of which clearly indicated that her tumor was cancerous. (R. at 583.) She reported that she was scheduled to begin Tamoxifen therapy in November 2000. (R. at 582-83.)

At the second hearing, Adams estimated that she could stand for a total of less than one hour, but for only 20 minutes without interruption. (R. at 575.) She further estimated that she could sit for a total of only two hours. (R. at 574-75.) Adams testified that she occasionally drove to town, a distance of two miles, and could ride in a car for only one hour without stopping due to numbness of her legs. (R. at 36, 584-85.) She further testified that she could lift items weighing up to only five pounds without pain. (R. at 36-37, 587.) She estimated that she could walk for approximately one-eighth of a mile. (R. at 576.) Adams testified that before her back problems, she mowed her lawn, camped and fished. (R. at 37.) She further testified that she used to perform all of the housework, which her husband and neighbors then currently performed. (R. at 37.) Adams testified that she occasionally watched television, but noted that her pain made it difficult to sit and concentrate. (R. at 38.) She stated that she made her bed, made coffee, talked to her neighbor on the telephone, watched some television, read a little, dusted furniture, grocery shopped weekly, cooked, performed laundry with her husband's assistance and did some scrapbooking. (R. at 42-43, 586-88.) At her second hearing, Adams testified that she cooked approximately three days per week and that she visited her sick father-in-law to set out his weekly medications. (R. at 586-88.)

Dr. Edward Alan Griffin, M.D., a medical expert, testified at Adams's second hearing, diagnosing degenerative arthritis of the lumbar spine and hypertension. (R. at 589-95.) He concurred with Dr. Bendigo's functional capacity assessment of April 11, 1997. (R. at 592.) Conversely, Dr. Griffin disagreed with Dr. Molony's functional capacity assessment of April 30, 1997, because it was not supported by a 1994 MRI, nor were the physical findings consistent with the severity of the findings contained in

the rest of the record. (R. at 594.) Dr. Griffin testified that while it was possible that Adams's condition had changed, that there was no indication that it had done so since the 1994 MRI. (R. at 594.) He noted that Dr. Molony's and Dr. Kiser's assessments were similar. (R. at 594.)

Donna J. Bardsley, a vocational expert, also was present and testified at Adams's second hearing. (R. at 595-605.) Bardsley classified Adams's past relevant work as a sewing machine operator as light and semi-skilled with no transferable skills. (R. at 597.) Bardsley was asked to consider a hypothetical individual of Adams's age, education and past relevant work, who was limited as set forth in Dr. Griffin's testimony. (R. at 598.) Bardsley testified that such an individual could perform the light jobs of a cashier, an information clerk, an order clerk, a hand packager, a sorter, an assembler, an inspector, a ticket seller and a cafeteria attendant. (R. at 598.) Bardsley was next asked to consider the same individual, but who was limited as set forth in Dr. Molony's assessment. (R. at 599.) Bardsley testified that such an individual could perform no jobs. (R. at 599.) Bardsley likewise testified that an individual limited as set forth in Adams's testimony and an individual who was limited as set forth in Dr. Kiser's assessment, could perform no jobs. (R. at 599-600.) Finally, Bardsley testified that such an individual who also required two naps per day would not be able to perform any jobs, nor would the same individual who also had difficulty using her hands as Adams testified. (R. at 604.)

In rendering his decision, the ALJ reviewed records from Dr. Donald R. Williams, M.D., a state agency physician; Dr. Kenneth D. Kiser, M.D.; Dr. Galen R. Smith, M.D.; Dr. Patrick A. Molony, M.D.; Holston Valley Hospital and Medical

Center; Dr. Leopoldo L. Bendigo, M.D.; Dr. Stan Merka, M.D.; Dr. Robert T. Strang Jr., M.D.; Dr. Milan Sasek, M.D.; Lonesome Pine Hospital; Dr. Ruth Ann Nevils, M.D.; Dr. Perry Grossman, M.D., a state agency physician; Julie Jennings, Ph.D., a state agency psychologist; Powell Valley Family Physicians; Cancer Outreach Services; and Kingsport Hematology-Oncology.

The record indicates that Adams saw Dr. Kenneth D. Kiser, M.D., her treating physician, from April 1993 through October 2000. Over this time period, Adams complained of intermittent low back pain, (R. at 115, 125, 131, 133-34, 136-37, 145, 147-49, 151, 153-54, 156, 158-60, 162, 165, 190-92, 194, 208, 210-11, 220, 249, 252, 377-81, 386, 388-89, 461, 466, 469-70, 473, 475), occasionally associated with radiation into the lower extremities. (R. at 115-16, 146, 159.) She repeatedly exhibited tenderness over the L4-L5 area of the spine, (R. at 116, 125, 133, 137, 147, 376, 381-82, 387, 468, 470, 473), positive straight leg raising, (R. at 118-19, 125, 147, 150, 376, 385, 467-68, 470, 473), and paraspinous muscle spasm in the lumbar area. (R. at 162, 165, 470.) Although Adams also exhibited some decreased range of motion of the back and some decreased sensation, her reflexes generally remained intact. (R. at 118-19, 150-51, 158.)

On February 7, 1994, Adams saw Dr. Robert T. Strang Jr., M.D., with complaints of chronic low back pain radiating down the right leg. (R. at 157.) Dr. Strang noted that Adams was able to maintain motor power and to stand on toes and heels. (R. at 157.) She had a mildly positive straight leg raising test and was diagnosed with L5-S1 disc disease. (R. at 157.) Dr. Strang opined that Adams was "probably ... a surgical candidate." (R. at 157.)

In March 1994, Adams underwent a CT scan which showed significant degenerative changes of the facet joints on both sides of the L5-S1 level of the spine and a large herniated disc nucleus at the L5-S1 level. (R. at 156.) She began receiving Toradol injections approximately every three weeks, and continued to do so through the time of her second hearing. (R. at 156, 577.) In April 1994, Dr. Kiser recommended surgical intervention. (R. at 154.) However, a preoperative MRI performed the same month revealed only mild degeneration of the disc at the L1-L2 and L4-L5 levels of the spine. (R. at 181.) Based on this evidence, Adams's surgery was canceled. (R. at 181.) The following month, Adams began to complain of incontinence. (R. at 153.)

On May 19, 1994, Adams underwent an electromyogram, ("EMG"), and nerve conduction study, which revealed right L5 radiculopathy. (R. at 181.) Dr. Smith performed a lumbar myelogram and a CT scan on June 2, 1994, which revealed a diffuse annular bulge at the L4-L5 intervertebral disc. (R. at 183.) Adams was diagnosed with lumbar radiculopathy versus neuropathy affecting the right leg and urinary incontinence. (R. at 184.) Dr. Smith opted to pursue nonoperative treatment at that time. (R. at 182.)

On July 29, 1994, Dr. Kiser diagnosed Adams with labile hypertension and a herniated L5-S1 disc with associated sensation changes. (R. at 151.) He restricted her to working no more than nine hours per day with 48 hours off on the weekends. (R. at 151.) In September 1994, Adams was diagnosed with a previously herniated disc, which apparently improved to a bulging disc with therapy. (R. at 150.) She was prescribed a transcutaneous electrical nerve stimulation, ("TENS"), unit, after which she reported markedly improved back pain. (R. at 140, 145.)

On July 5, 1995, Adams saw Dr. Milan Sasek, M.D., with complaints of exacerbation of low back pain with radiation into the lower extremities. (R. at 139.) She exhibited marked palpational sensitivity of the S1 and L5 regions bilaterally with lumbosacral paravertebral muscle spasm. (R. at 139.) Adams was diagnosed with acutely worsened low back pain. (R. at 139.) She was given a Toradol injection and Lodine and was advised to begin exercises. (R. at 139.)

In November 1995, Adams was diagnosed with temporomandibular joint, ("TMJ"), arthralgias. (R. at 135.) In November and December 1995, her hypertension was controlled. (R. at 134-35.) She also was diagnosed with acid peptic disease with esophageal reflux at that time. (R. at 134.) By February 1996, Adams began to complain of headaches, right shoulder pain and left breast pain. (R. at 133.) She exhibited a supraspinatous sign over the right shoulder and received an epidural steroid injection which resolved her pain. (R. at 132-33.) Adams was diagnosed with right shoulder biceps tendonitis, right shoulder subacromial bursitis and fibrocystic disease with minimal mastitis. (R. at 132.) By February 26, 1996, Adams's headaches were somewhat improved. (R. at 130.) She was diagnosed with labile hypertension, which improved the following month. (R. at 129-30.) On March 20, 1996, Adams again complained of severe headaches. (R. at 128.) Although she exhibited tenderness over the trapezius muscles and cervical area, her range of motion was normal. (R. at 128.) Nonetheless, she was released from work for the following week. (R. at 128.) Later that month, Adams reported somewhat improved neck pain with markedly decreased tenderness. (R. at 127.) However, she was released from work for two months. (R. at 127.)

By April 2, 1996, Adams reported marked improvement in her headaches and improved cervical pain. (R. at 126.) By May 1996, she reported numbness of the fourth and fifth digits of the right hand. (R. at 124.) At that time, she had a positive Tinel's sign[3] on the right ulnar area and was diagnosed with ulnar radiculopathy of the right elbow. (R. at 124.)

Dr. Donald R. Williams, M.D., a state agency physician, performed a physical residual functional capacity assessment on May 2, 1996, finding that Adams could perform medium work.[4] (R. at 75-82.) He found no postural, manipulative, visual, communicative or environmental limitations. (R. at 77-79.)

Adams continued to see Dr. Kiser from May through August 1996. In May and July 1996, she reported some improvement in her headaches. (R. at 115, 123.) Dr. Kiser noted improved hypertension, (R. at 115, 122), and improved ulnar radiculopathy of the right elbow. (R. at 122.) Adams also reported incontinence and vaginal numbness. (R. at 119.) On June 12, 1996, Dr. Kiser completed a Medical Assessment Of Ability To Do Work-Related Activities (Physical), finding that Adams could carry items weighing five pounds for less than one-third of the day, could stand and/or walk for a total of one hour, but could stand for only 10 minutes and walk for only two minutes without interruption. (R. at 170-74.) Dr. Kiser further found that Adams could

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[3]Tinel's sign is a tingling sensation in the distal end of a limb when percussion is made over the site of a divided nerve. It indicates a partial lesion or beginning regeneration of the nerve. *See* DORLAND'S ILLUSTRATED MEDICAL DICTIONARY, ("Dorland's"), 1526 (27th ed. 1988).

[4]Medium work involves lifting items weighing up to 50 pounds at a time with frequent lifting or carrying of items weighing up to 25 pounds. If someone can perform medium work, she also can perform light and sedentary work. *See* 20 C.F.R. §§ 404.1567(c), 416.967(c) (2004).

sit for a total of four hours, but for only one hour without interruption. (R. at 171.) He concluded that Adams could never climb, stoop, kneel, balance, crouch or crawl. (R. at 172.) He further concluded that Adams's abilities to reach, to feel and to push and/or pull were affected by her impairments. (R. at 172.) Finally, Dr. Kiser found that Adams should not work around heights, moving machinery, temperature extremes, humidity and vibration. (R. at 173.) In July 1996, Dr. Kiser opined that Adams was disabled. (R. at 115.)

Dr. Williams completed another physical residual functional capacity assessment on September 10, 1996, again finding that Adams could perform medium work. (R. at 89-96.) Dr. Williams further found that Adams could frequently climb, balance, kneel and crawl, but only occasionally stoop and crouch. (R. at 91.) He again found no manipulative, visual, communicative or environmental limitations. (R. at 92-93.)

On October 15, 1996, Dr. Kiser diagnosed Adams with right ulnar radiculopathy with lateral epicondylitis.[5] (R. at 191, 394.) After Adams reported a lump in her left breast in November 1996, an ultrasound revealed a lesion. (R. at 192.) From January through April 1997, Adams was diagnosed with lumbago[6] and malignant essential hypertension. (R. at 205, 207, 211.) In March 1997, she complained of shortness of breath and increased peripheral edema. (R. at 210.) A physical examination revealed 2+ peripheral edema, but an echocardiogram revealed negative left ventricular hypertrophy. (R. at 204, 210.) A chest x-ray revealed no significant abnormalities. (R.

[5]Epicondylitis is the inflammation of the epicondoyle or of the tissues adjoining the epicondoyle of the humerus. *See* Dorland's at 565.

[6]Lumbago refers to pain in the lumbar region. *See* Dorland's at 956.

at 204, 449.) Adams was diagnosed with dyspnea and was given a Proventil inhaler. (R. at 209.) Later that month, Adams's shortness of breath was markedly improved. (R. at 223.)

Adams saw Dr. Stan Merka, M.D., at Dr. Kiser's referral for evaluation of a left breast mass. (R. at 216.) Dr. Merka performed a biopsy of Adams's left breast on December 2, 1996. (R. at 215, 217-18.) He diagnosed her with fibrocystic disease with apocrine metaplasia from the left breast. (R. at 217-18, 407, 409.) By December 9, 1996, Adams had no major complaints despite some ecchymosis of the left breast. (R. at 214.) At that time, she was discharged from surgical follow-up. (R. at 214.) She underwent a right breast biopsy on June 25, 1997, after which she was diagnosed with fibrocystic changes with stromal fibrous change, microcysts and papillary apocrine metaplasia. (R. at 405.)

On April 11, 1997, Dr. Leopoldo L. Bendigo, M.D., completed a medical consultant report at the request of the Virginia Department of Rehabilitative Services. (R. at 195-97.) A physical examination revealed minimal tenderness over the lumbosacral region with no evidence of paraspinal spasm and no evidence of spinal deformities, scoliosis or kyphosis. (R. at 196-97.) Straight leg raising was positive at 90 degrees bilaterally, but there was no evidence of any weakness or neurological deficits. (R. at 197.) Knee jerks were 2+, ankle jerks were 1+, there was a negative clonus and Babinski's sign[7] was flexor. (R. at 197.) Adams was able to heel and toe walk without difficulty, and she was able to duck waddle with only minimal difficulty.

[7]Babinski's sign is a loss or lessening of the Achilles' tendon reflex in sciatica. *See* Dorland's at 1520.

(R. at 197.) Dr. Bendigo diagnosed Adams with lumbar radicular syndrome and a bulging disc at the L4-L5 level of the spine. (R. at 197.) He recommended conservative treatment with the use of nonsteroidal anti-inflammatory drugs and analgesics on an as needed basis. (R. at 197.)

Dr. Bendigo also completed a Medical Assessment Of Ability To Do Work-Related Activities (Physical), finding that Adams could lift items weighing up to 35 pounds occasionally and up to 15 pounds frequently. (R. at 198-202.) He further found that Adams could stand and/or walk for a total of six hours each, but for only one hour each without interruption. (R. at 198.) Likewise, Dr. Bendigo found that Adams could sit for a total of six hours, but for only one hour without interruption. (R. at 199.) Dr. Bendigo concluded that Adams could never climb or balance, but could occasionally stoop, kneel, crouch and crawl. (R. at 199.) He found that her ability to push and/or pull was moderately affected by her impairments and that she was moderately restricted from working around heights, moving machinery, temperature extremes, humidity and vibration. (R. at 199-200.) Dr. Bendigo found that Adams had normal range of motion except for the dorsolumbar spine, in which she had 40 degrees flexion, 10 degrees extension, 10 degrees right lateral flexion and 10 degrees left lateral flexion. (R. at 201.)

On December 29, 1997, x-rays of Adams's cervical and lumbar spines, as well as her left foot and ankle, revealed normal findings with the exception of soft tissue swelling of the lateral aspect of the ankle. (R. at 404.) In July 1998, she complained of paresthesias of the right upper extremity. (R. at 468.) A physical examination

revealed positive Tinel's and Phalen's sign.[8] (R. at 468.) She was diagnosed with right carpal tunnel syndrome and was given a wrist splint to wear. (R. at 468.) In September 1998, Adams was diagnosed with cervicalgia[9] and lumbago. (R. at 393.) The following month, Dr. Kiser again diagnosed Adams with right carpal tunnel syndrome. (R. at 392.) Adams underwent a bilateral mammogram on October 23, 1998, which revealed a need for further testing. (R. at 391.) An ultrasound of the left breast was recommended. (R. at 477.) On February 11, 1999, Adams underwent a needle localization with open biopsy of two left breast lesions at Lonesome Pine Hospital. (R. at 417-23.) Microscopic findings were compatible with a hyalinized fibroadenoma and fibrocystic changes associated with patchy, mild chronic inflammation and patchy, dense stromal fibrosis. (R. at 421.)

In May 1999, Adams received a Celestone and Xylocaine injection in the subacromial area with resolution of neck pain. (R. at 380.) She was diagnosed with cervicalgia, lumbago, epigastric pain, benign essential hypertension and shoulder joint pain. (R. at 376-77, 379-82, 388-89.) In July 1999, Adams was diagnosed with improved lumbago. (R. at 377.) On February 3, 2000, a mammogram revealed negative findings. (R. at 397-98.) By May 2000, Adams complained of pain in the left shoulder and neck. (R. at 369.)

On February 10, 2000, Dr. Williams completed another physical residual functional capacity assessment, this time finding that Adams could perform only light

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[8]Phalen's maneuver is a test for carpal tunnel syndrome. *See* Dorland's at 978.

[9]Cervicalgia refers to any painful condition of the neck. *See* Dorland's at 46, 307.

work. (R. at 430-37.) He found no postural, manipulative, visual, communicative or environmental limitations. (R. at 433-35.) This assessment was affirmed by Dr. Michael J. Hartman, M.D., another state agency physician, on June 6, 2000. (R. at 437.)

On March 9, 2000, Dr. Perry Grossman, M.D., a state agency physician, completed a review of Dr. Williams's physical residual functional capacity assessment, in which he agreed, for the most part, with it. (R. at 429, 438-39.) In addition to Dr. Williams's findings, Dr. Grossman noted that Adams's exertional limitations were presumably related to her back pain, and he limited her to stooping and crawling on an occasional basis. (R. at 438.)

On May 26, 2000, Adams was randomized for the Tamoxifen trial. (R. at 485, 540.) However, on June 21, 2000, her hypertension was elevated and she was informed that it must be under control in order to be eligible for the trial. (R. at 484, 539.)

Adams saw Dr. Patrick A. Molony, M.D., on August 30, 2000, for an evaluation of her low back pain. (R. at 478-80.) Upon examination, Dr. Molony noted that Adams had palpable peripheral pedal pulses without edema, proprioception of the toes upward and downward was normal and bilateral plantar flexion and her deep tendon reflexes were equal. (R. at 479.) Adams's grip strength was reduced by approximately 10 percent in the left hand. (R. at 479.) Range of motion of the wrists and elbows was normal. (R. at 479.) Adams's left shoulder was reduced in abduction and forward elevation to approximately 100 degrees. (R. at 479.) Range of motion of the ankles and knees were normal, and range of motion of the hips was complete, but with pain

in the low back. (R. at 479.) Straight leg raising was positive bilaterally. (R. at 479.) Adams's flexion of the dorsolumbar spine also was reduced. (R. at 480.) She was unable to heel and toe walk. (R. at 480.) Dr. Molony found that Adams could sit for two hours, stand for one hour, walk for one-quarter of a mile, lift items weighing up to five pounds, carry items no more than 10 yards and travel for one to one and a half hours. (R. at 480.) Dr. Molony found that Adams's ability to handle objects was satisfactory. (R. at 480.) He diagnosed her with back pain with radiculopathy to the right leg, neck and left shoulder pain, hypertension, fibrocystic disease of the breast and duodenal peptic ulcer. (R. at 480.)

Dr. Molony also completed a Medical Assessment Of Ability To Do Work-Related Activities (Physical), concluding that Adams could occasionally lift and/or carry items weighing up to five pounds, that she could stand and/or walk for a total of four hours, but for only one to one and a half hours without interruption, and that she could sit for six hours, but for only two hours without interruption. (R. at 481-83.) Dr. Molony further found that Adams should never stoop, kneel, crouch or crawl, but could occasionally climb. (R. at 482.) He concluded that Adams's abilities to feel and to push and/or pull were affected by her impairments. (R. at 482.) Dr. Molony found that Adams should not work around heights, moving machinery, temperature extremes and humidity. (R. at 483.)

Dr. Kiser completed a Medical Assessment Of Ability To Do Work-Related Activities (Physical) in October 2000, finding that Adams could occasionally lift items weighing up to five pounds, but that she could not lift any weight on a frequent basis. (R. at 497-501, 553-57.) He further found that Adams could stand and/or walk for a

total of four hours, but for only one hour without interruption, and that she could sit for a total of less than six hours, but for less than two hours without interruption. (R. at 498, 554.) Dr. Kiser concluded that Adams could never climb, stoop, kneel, balance, crouch or crawl. (R. at 499, 555.) He further concluded that Adams's abilities to reach, to handle, to feel and to push and/or pull were affected by her impairments. (R. at 499, 555.) Dr. Kiser found that Adams should not work around heights, moving machinery, temperature extremes, noise, humidity and vibration. (R. at 500, 556.)

III. Analysis

The Commissioner uses a five-step process in evaluating DIB and SSI claims. *See* 20 C.F.R. §§ 404.1520, 416.920 (2004); *see also Heckler v. Campbell*, 461 U.S. 458, 460-62 (1983); *Hall v. Harris*, 658 F.2d 260, 264-65 (4th Cir. 1981). This process requires the Commissioner to consider, in order, whether a claimant 1) is working; 2) has a severe impairment; 3) has an impairment that meets or equals the requirements of a listed impairment; 4) can return to her past relevant work; and 5) if not, whether she can perform other work. *See* 20 C.F.R. §§ 404.1520, 416.920 (2004). If the Commissioner finds conclusively that a claimant is or is not disabled at any point in this process, review does not proceed to the next step. *See* 20 C.F.R. §§ 404.1520(a), 416.920(a) (2004).

Under this analysis, a claimant has the initial burden of showing that she is unable to return to her past relevant work because of her impairments. Once the claimant establishes a prima facie case of disability, the burden shifts to the Commissioner. To satisfy this burden, the Commissioner must then establish that the claimant has the

residual functional capacity, considering the claimant's age, education, work experience and impairments, to perform alternative jobs that exist in the national economy. *See* 42 U.S.C.A. §§ 423(d)(2)(A), 1382c(a)(3)(A)-(B) (West 2003); *McLain v. Schweiker*, 715 F.2d 866, 868-69 (4th Cir. 1983); *Hall*, 658 F.2d at 264-65; *Wilson v. Califano*, 617 F.2d 1050, 1053 (4th Cir. 1980).

By decision dated November 16, 2000, the ALJ denied Adams's claims. (R. at 274-83.) The ALJ found that Adams met the disability insured status requirements of the Act on March 20, 1996, and continued to meet them through the date of the decision. (R. at 281.) The ALJ also found that Adams had not engaged in substantial gainful activity since March 20, 1996. (R. at 281.) The ALJ found that Adams had severe impairments, namely degenerative arthritis of the lumbar spine, degenerative disc disease of the cervical spine and hypertension, but he found that Adams did not have an impairment or combination of impairments listed at or medically equal to one listed at 20 C.F.R. Part 404, Subpart P, Appendix 1. (R. at 281.) The ALJ found that Adams's allegations were not credible to the extent alleged. (R. at 281.) The ALJ concluded that Adams had the residual functional capacity to perform light work, diminished by an inability to stand, walk or sit for more than one hour each without interruption, an ability to only occasionally stoop, kneel, crouch and crawl, an inability to climb or kneel, a restriction in the pushing and pulling of foot controls and a restriction from exposure to heights, moving machinery, temperature extremes, humidity and vibration. (R. at 282.) Thus, the ALJ found that Adams was unable to perform her past relevant work as a sewing machine operator. (R. at 282.) Based on Adams's age, education and residual functional capacity and the testimony of a vocational expert, the ALJ found that a significant number of jobs existed in the national economy

that Adams could perform. (R. at 283.) Thus, the ALJ found that Adams was not under a disability as defined in the Act at any time through the date of the decision and was not eligible for benefits. (R. at 283.) *See* 20 C.F.R. §§ 404.1520(g), 416.920(g) (2004).

Adams argues that the ALJ erred in his weighing of the medical evidence. Specifically, Adams contends that the ALJ erred by rejecting the opinions of Dr. Kiser, her treating physician, and Dr. Molony, a consultative examiner, in favor of the medical expert, Dr. Griffin, in concluding that she retained the capacity to perform a diminished degree of light work. (Memorandum In Support Of Plaintiff's Motion For Summary Judgment, ("Plaintiff's Brief"), at 9-23.) Adams also argues that the ALJ erred by finding that her testimony was not credible. (Plaintiff's Brief at 23-24.)

As stated above, the court's function in this case is limited to determining whether substantial evidence exists in the record to support the ALJ's findings. This court must not weigh the evidence, as this court lacks authority to substitute its judgment for that of the Commissioner, provided her decision is supported by substantial evidence. *See Hays*, 907 F.2d at 1456. In determining whether substantial evidence supports the Commissioner's decision, the court also must consider whether the ALJ analyzed all of the relevant evidence and whether the ALJ sufficiently explained his findings and his rationale in crediting evidence. *See Sterling Smokeless Coal Co. v. Akers*, 131 F.3d 438, 439-40 (4th Cir. 1997).

Thus, it is the ALJ's responsibility to weigh the evidence, including the medical evidence, in order to resolve any conflicts which might appear therein. *See Hays*, 907

F.2d at 1456; *Taylor v. Weinberger*, 528 F.2d 1153, 1156 (4th Cir. 1975). Furthermore, while an ALJ may not reject medical evidence for no reason or for the wrong reason, *see King v. Califano*, 615 F.2d 1018, 1020 (4th Cir. 1980), an ALJ may, under the regulations, assign no or little weight to a medical opinion, even one from a treating source, based on the factors set forth at 20 C.F.R. §§ 404.1527(d), 416.927(d), if he sufficiently explains his rationale and if the record supports his findings.

Adams argues that the ALJ erred by giving controlling weight to the testimony of Dr. Griffin regarding her residual functional capacity. (Plaintiff's Brief at 9-23.) The Fourth Circuit Court of Appeals has enunciated several principles regarding the treatment of the testimony from a nonexamining, nontreating physician. In *Martin v. Sec'y of Dep't of Health, Educ. & Welfare*, 492 F.2d 905, 908 (4th Cir. 1974), the court indicated that such testimony should be discounted and does not constitute substantial evidence when it is totally contradicted by other evidence in the record. However, the court ruled in *Kyle v. Cohen*, 449 F.2d 489 (4th Cir. 1971), that the testimony of a nonexamining, nontreating physician can be used and relied upon if it is consistent with the record. Finally, "if the medical expert testimony from examining or treating physicians goes both ways, an ALJ's determination coming down on the side on which the [nonexamining], [nontreating] physician finds himself should stand." *Gordon v. Schweiker*, 725 F.2d 231, 235 (4th Cir. 1984). Based on my review of the record, I find that substantial evidence supports the ALJ's residual functional capacity finding, as set forth above.

Dr. Griffin diagnosed Adams with degenerative arthritis of the lumbar spine and hypertension. (R. at 591-92.) He concurred with Dr. Bendigo's residual functional

capacity assessment, dated April 11, 1997. (R. at 198-200, 592.) However, Dr. Griffin disagreed with Dr. Molony's assessment, dated August 30, 2000, because it was not supported by the 1994 MRI, nor were Dr. Molony's physical findings consistent with the severity of the findings contained in the rest of the record. (R. at 478-80, 594.) Dr. Griffin noted that Dr. Molony's and Dr. Kiser's assessments were similar. (R. at 594.) For the following reasons, I find that substantial evidence supports the ALJ's weighing of the medical evidence.

First, as noted by the ALJ, Dr. Kiser's and Dr. Molony's restrictions are not supported by the objective medical evidence. (R. at 279.) Instead, they appear to be based on Adams's subjective complaints. (R. at 279.) Next, the ALJ correctly found that Dr. Kiser's findings are not supported by his own treatment notes. (R. at 279.) Finally, the ALJ correctly noted that Dr. Molony's restrictions are not supported by his own narrative report. (R. at 279.)

It is well-settled that subjective allegations alone will not suffice to establish disability. Instead, there also must be "medical signs and laboratory findings" to show a medical impairment that could reasonably be expected to produce the alleged symptoms. *See* 20 C.F.R. §§ 404.1529(a), 416.929(a) (2004). In June 1994, Dr. Kiser diagnosed Adams with a herniated disc despite the MRI the previous month showing only mild degeneration of the spine. (R. at 151, 181.) In Dr. Kiser's June 1996, assessment, he concluded that Adams could lift items weighing up to only five pounds and could stand and/or walk for a total of one hour each, but could stand for only 10 minutes and walk for only two minutes without interruption. (R. at 170-71.) Dr. Kiser completed another assessment in October 2000, finding that Adams could lift items

weighing up to only five pounds occasionally, but that she could lift no weight on a frequent basis. (R. at 497-501, 553-57.) Dr. Molony similarly found that Adams could occasionally lift and/or carry items weighing up to only five pounds, that she could stand and/or walk for a total of four hours, but for only one to one and a half hours without interruption, and that she could sit for six hours, but for only two hours without interruption. (R. at 481-83.) There simply is no objective evidence contained in the record to support such restrictions. In fact, such restrictions are explicitly contradicted by the other medical evidence of record. In May and September 1996, Dr. Williams found that Adams could perform medium work. (R. at 75-82, 89-96.) Furthermore, Dr. Bendigo found that Adams could lift items weighing up to 35 pounds occasionally and up to 15 pounds frequently. (R. at 198-202.) He further found that she could stand, walk and/or sit for a total of six hours each. (R. at 198-99.) In March 2000, Dr. Grossman concurred with Dr. Williams's assessment. (R. at 429, 438-39.)

In addition to the ALJ's reasoning, I further note that Adams's activities of daily living belie any contention that she is restricted as set forth in Dr. Kiser's and Dr. Molony's assessments. In an undated daily activities questionnaire, Adams reported cooking daily, performing household chores weekly, grocery shopping weekly, paying bills, washing dishes, doing laundry, watching television, reading, working crossword puzzles, visiting friends and relatives and talking on the telephone. (R. at 345-49.) She reported that she did not need assistance with her personal care. (R. at 349.)

Conversely, the ALJ accepted the opinion of Dr. Griffin, who concurred with Dr. Bendigo's assessment. (R. at 279.) The ALJ correctly noted that Dr. Bendigo's assessment was internally consistent and was supported by other medical evidence of

record. (R. at 279.) Dr. Bendigo's findings, as set forth above, are consistent with his narrative report in which he indicated that Adams exhibited only minimal tenderness over the lumbosacral region with no evidence of paraspinal spasm and no evidence of spinal deformities, scoliosis or kyphosis. (R. at 196-97.) Straight leg raising was positive, but there was no evidence of weakness or neurological deficits. (R. at 197.) Knee jerks were 2+, ankle jerks were 1+, there was negative clonus and Babinski's sign, and Adams was able to heel and toe walk and duck waddle with minimal difficulty. (R. at 197.) Moreover, as previously mentioned, Dr. Bendigo's findings are supported by those of Dr. Williams and Dr. Grossman. Finally, Dr. Bendigo's findings are supported by Adams's activities of daily living.

For these reasons, I find that substantial evidence supports the ALJ's rejection of Dr. Kiser's and Dr. Molony's assessments in favor of Dr. Griffin's testimony, which was based on the findings of Dr. Bendigo and the state agency physicians.

Adams also argues that the ALJ erred by finding that his testimony was not credible. (Plaintiff's Brief at 23-24.) The Fourth Circuit has adopted a two-step process for determining whether a claimant is disabled by pain. First, there must be objective medical evidence of the existence of a medical impairment which could reasonably be expected to produce the actual amount and degree of pain alleged by the claimant. *See Craig v. Chater*, 76 F.3d 585, 594 (4th Cir. 1996). Second, the intensity and persistence of the claimant's pain must be evaluated, as well as the extent to which the pain affects the claimant's ability to work. *See Craig*, 76 F.3d at 595. Once the first step is met, the ALJ cannot dismiss the claimant's subjective complaints simply because objective evidence of the pain itself is lacking. *See Craig*, 76 F.3d at 595.

This does not mean, however, that the ALJ may not use objective medical evidence in evaluating the intensity and persistence of pain. In *Craig*, the court stated:

> Although a claimant's allegations about [her] pain may not be discredited solely because they are not substantiated by objective evidence of the pain itself or its severity, they need not be accepted to the extent they are inconsistent with the available evidence, including objective evidence of the underlying impairment, and the extent to which that impairment can reasonably be expected to cause the pain the claimant alleges [she] suffers....

76 F.3d at 595.

Based on my review of the ALJ's decision, I find that the ALJ properly considered Adams's subjective complaints of pain and found that they were not totally credible. (R. at 279.) The ALJ found that Adams had medical impairments which could reasonably be expected to cause some pain or discomfort, but not to the degree alleged. (R. at 279.) He found that Adams's complaints of back pain were described as "intermittent." (R. at 279.) Moreover, the ALJ noted that Adams's activities of daily living, which included cooking, grocery shopping, performing household chores, reading, watching television, using the telephone, scrapbooking, working crossword puzzles, visiting relatives and organizing her father-in-law's medications, were not indicative of debilitating or disabling pain or other symptoms. (R. at 279.) Thus, the ALJ concluded that Adams's allegations of disability simply were not supported by the objective evidence of record. (R. at 279.) Based on this, I find that substantial evidence exists to support the ALJ's finding on this issue.

PROPOSED FINDINGS OF FACT

As supplemented by the above summary and analysis, the undersigned now submits the following formal findings, conclusions and recommendations:

1. **Substantial evidence exists in the record to support the ALJ's weighing of the medical evidence and subsequent physical residual functional capacity assessment; and**

2. Substantial evidence exists in the record to support the Commissioner's finding that Adams was not disabled under the Act.

RECOMMENDED DISPOSITION

The undersigned recommends that the court deny Adams's motion for summary judgment and affirm the Commissioner's decision denying benefits.

Notice to Parties

Notice is hereby given to the parties of the provisions of 28 U.S.C.A. § 636(b)(1)(C):

> Within ten days after being served with a copy [of this Report and Recommendation], any party may serve and file written objections to such proposed findings and recommendations as provided by rules of court. A judge of the court shall make a de novo determination of those portions of the report or specified proposed findings or recommendations to which objection is made. A judge of the court may accept, reject, or modify, in

> whole or in part, the findings or recommendations made by the magistrate [judge]. The judge may also receive further evidence or recommit the matter to the magistrate [judge] with instructions.

Failure to file timely written objections to these proposed findings and recommendations within 10 days could waive appellate review. At the conclusion of the 10-day period, the Clerk is directed to transmit the record in this matter to the Honorable Glen M. Williams, Senior United States District Judge.

The Clerk is directed to send certified copies of this Report and Recommendation to all counsel of record at this time.

DATED: This 7th day of February, 2005.

/s/ Pamela Meade Sargent
UNITED STATES MAGISTRATE JUDGE